The following information must be completed by the health care professional listed on the previous page.

_____

Date of last visit: _____

1. Diagnoses:

   _____

2. Date of diagnoses: _____

3. For environmental allergies, please list specific allergens:

   _____

4.

   _____

- ⃠
- ⃠
- ⃠
- ⃠

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

12. Procedures/assessments used to diagnose (please attach copies of assessment results used in making/ confirming diagnosis):

- [ ] a. Spirometry
- [ ] b. Allergy Testing
- [ ] c. Evaluation by allergy/asthma specialist
- [ ] d. Other (please explain):

13. Check the following that apply to this student:

- [ ] a. Was treated in the emergency room for this condition within the last year
- [ ] b. Has received in-patient treatment for this condition within the last year
- [ ] c. Prescribed allergy shots
- [ ] d. Prescribed short acting rescue inhaler
- [ ] e. Uses an epinephrine pen (i.e. Epi-pen)
- [ ] f. Recommended to use oral maintenance medications (including antihistut -15.8-16pos . (d s)2. f.hing e is
- [ ]

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider.

Signature of Health Care Provider: _____

Printed Name: _____

License #: _____ Date: _____

Thank you for your assistance. You may return your report to the Office of Disability Services via email at **ODS@csuohio.edu** or by fax at **(216) 687-2343**.

Please call **(216) 687-2015** if you require additional information. Please attach any additional reports or relevant information (audiology reports, neuropsychological evaluations, etc). All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).